Patient's Name:	LAST / FIRST	/ MI	Т	elephone N	lumber:			Hospital	l:			
Address:	NUMBER / STREET	APT NO / CITY / STAT			ZIP CO		_Patient	Chart N	lo.:			
• • • • • • • • • • • • • • • • • • • •	•••••		FIER INFORMATION IS	NOT TRANSM				Гоина	Annual OM	IB No. 0920-072		
HUMAN SERVICES. C.S. CD	C • National	Center for	Immuniza	ation a	and Re	espirat	tory			IB No. 0920-072		
BUNKAN SERVICES CE. CD	LE	GIONEL (DISEASE CA	LOSIS (r			EAFER-MEALTHIER-PEOPLE S		
N. TH. V. d.3.Q	С	enters for Disease (artment of Health Control and Preven htp://www.cdc.gov/l	tion (CDC), A	Atlanta, Ge		4027	Case No		C use only)		
1. State Health Dept. (Case No.: 2. Reporting	State: 3. Count	ty of Residence:	4. Sta	ate of Resi	idence: 5.	Occup	ation:				
Days					Ethnicity: Hispanic/Latino 9 Unknown 1 America Alaska N Not Hispanic/Latino 1 Asian				ın Indian/ . Native Hawaiian or			
10. Diagnosis: (check or	•	clinical or X-ray dia	agnosed)	11. Date of onset of	symptom f legionello	osis:	1		of first repor health at ar			
Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed) Pontiac Fever (fever and myalgia without pneumonia) Other (e.g., endocarditis, wound infection):					Day	Year Mo. Day				Year		
13. Was the patient ho	spitalized during treatme	ent for legionellosis	6? 1 Yes 2 N	lo 9 🗌 Unkno	own			14. Ou	tcome of illn			
If yes, date of admission	n: Mo. Day	Year	Hospital name: _					I -	Survived Died	3 Still ill 9 Unknown		
15. In the 10 days be	fore onset, did the pati	. , ,	•	`	Ū	care setting	js)?					
1		n yee, pieaee	complete the foll	owing table	Э.							
ACCOMMODATION NA		RESS	CITY	STATE	e. ZIP	COUNTRY	ROOI	ED 💳	DATES OF	-		
						COUNTRY	ROOI NUMB	ED 💳	DATES OF	F STAY DEPARTURE		
						COUNTRY		ED 💳		-		
						COUNTRY		ED 💳		-		
						COUNTRY		ED 💳		-		
						COUNTRY		ED 💳		-		
ACCOMMODATION NA	AME ADD	RESS	CITY	STATE	ZIP	COUNTRY		ED 💳		-		
*If yes, was this case rep	orted to CDC at travellegitore onset, did the pati	onella@cdc.gov?	CITY 1 Yes 2 No d time near a whin	STATE 9 Unknown	ZIP	p)?	NUMB	ER		-		
*If yes, was this case rep 16. In the 10 days bet (check one) 1 Yes 17. In the 10 days bef	orted to CDC at travellegifore onset, did the pating 2 No 9 Unknow fore onset, did the pating the p	onella@cdc.gov? ent get in or spendrous of the spendrous	CITY 1 Yes 2 No d time near a whire where:	STATE 9 Unknown	n i.e., hot tul	o)? _ If yes, lis	NUMB	ER ,	ARRIVAL	DEPARTURE		
*If yes, was this case rep 16. In the 10 days before (check one) 1 Yes 17. In the 10 days before apnea, COPD, asti	orted to CDC at travellegifore onset, did the pating 2 No 9 Unknow	onella@cdc.gov? ent get in or spend in If yes, describ ent use a nebulize ason?	CITY 1 Yes 2 No d time near a whire where: r, CPAP, BiPAP o	STATE 9 Unknown rlpool spa (i	n i.e., hot tul	o)? <i>If yes, lis</i> y therapy e	NUMB	er ,	ARRIVAL	DEPARTURE		
*If yes, was this case rep 16. In the 10 days bef (check one) 1 Yes 17. In the 10 days bef apnea, COPD, asti (check one) 1 Yes If yes, what type of	orted to CDC at travelleging fore onset, did the pating any other reading a man or for any ot	onella@cdc.gov? ent get in or spend on If yes, describ ent use a nebulize ason? on If yes, does thi evice? (check all t	CITY 1 Yes 2 No d time near a whine where: r, CPAP, BiPAP of six device use a huthat apply) 1 S	9 Unknown r any other umidifier? Sterile 1	n.i.e., hot tul	o)? If yes, lis y therapy e 2 □ No 9 1 □ Bottle	st dates quipme Unked 1	ent for the	e treatment	of sleep		
*If yes, was this case rep 16. In the 10 days bet (check one) 1 Yes 17. In the 10 days bet apnea, COPD, asti (check one) 1 Yes If yes, what type of 18. In the 10 days bet 18. In the 10 days bet 18.	orted to CDC at travellegifore onset, did the pating a ror or onset, did the pating a ror or any other real 2 \(\text{No} \) 8 \(\text{Unknown} \) Unknown	onella@cdc.gov? ent get in or spend on If yes, describ ent use a nebulize ason? n If yes, does thi evice? (check all tent visit or stay in	CITY 1 Yes 2 No d time near a whine where: r, CPAP, BiPAP o s device use a huthat apply) 1 S a healthcare setti	9 Unknown r any other midifier? Sterile 1 ing (e.g., ho	n.i.e., hot tuberespirator	o)? If yes, lis y therapy e 2 □ No 9 1 □ Bottle	st dates quipme Unked 1	ent for the	e treatment	of sleep		
*If yes, was this case rep 16. In the 10 days bet (check one) 1 Yes 17. In the 10 days bet apnea, COPD, asti (check one) 1 Yes If yes, what type of the check one) 1 Yes TYPE OF HEALTHCARE SETTING / FACILITY	orted to CDC at travellegifore onset, did the patina or for any other real 2 \(\sqrt{No} \) 9 \(\sqrt{Unknow} \) Unknow f water is used in the differe onset, did the patina or for any other real 2 \(\sqrt{No} \) 9 \(\sqrt{Unknow} \) Unknow f water is used in the differe onset, did the patina 2 \(\sqrt{No} \) 9 \(\sqrt{Unknow} \)	onella@cdc.gov? ent get in or spend on If yes, describ ent use a nebulize ason? n If yes, does thi evice? (check all tent visit or stay in	CITY 1 Yes 2 No d time near a whire e where: r, CPAP, BiPAP o s device use a hu that apply) 1 S a healthcare setti complete the foli IS THIS FACILITY ALSO A TRANSPLANT	9 Unknown r any other midifier? Sterile 1 ing (e.g., ho	n i.e., hot tul respirator 1 Yes Distilled Dispital, lone.	o)? If yes, lis y therapy e 2 □ No 9 1 □ Bottle	st dates quipme Unk ed 1 e/rehab/	ent for the	e treatment Other nursing facili	of sleep		
*If yes, was this case rep 16. In the 10 days bet (check one) 1 Yes 17. In the 10 days bet apnea, COPD, asti (check one) 1 Yes If yes, what type of 18. In the 10 days bet (check one) 1 Yes TYPE OF HEALTHCARE SETTING / FACILITY (CHECK ONE)	orted to CDC at travelleging fore onset, did the pating a ror or any other real 2 No 9 Unknown fore onset, did the pating a ror or any other real 2 No 9 Unknown fore onset, did the pating a ror onse	onella@cdc.gov? ent get in or spender of yes, describent use a nebulized ason? If yes, does this evice? (check all the ent visit or stay in the yes, please the NAME OF	CITY 1 Yes 2 No d time near a white where: Tr, CPAP, BiPAP of the tapply 1 Sa healthcare setting complete the following FACILITY ALSO A TRANSPLANT CENTER?	9 Unknown r any other midifier? Sterile 1 ing (e.g., ho	n i.e., hot tul respirator 1 Yes Distilled Dispital, lone.	o)? If yes, lis y therapy e 2 No 9 1 Bottle g term care	st dates quipme Unk ed 1 e/rehab/	er / / / / / / / / / / / / / / / / / / /	e treatment Other nursing facili	of sleep 1 Unknown ity, clinic)?		
*If yes, was this case rep 16. In the 10 days bet (check one) 1 Yes 17. In the 10 days bet apnea, COPD, asti (check one) 1 Yes If yes, what type of the check one) 1 Yes TYPE OF HEALTHCARE SETTING / FACILITY	orted to CDC at travellegifore onset, did the patina or for any other real 2 No 9 Unknow f water is used in the differe onset, did the pating 2 No 9 Unknow f water is used in the differe onset, did the pating 2 No 9 Unknow fore onset, did the pating 2 No 9 Unknow Type OF EXPOSURE	onella@cdc.gov? ent get in or spender of yes, describent use a nebulized ason? If yes, does this evice? (check all the ent visit or stay in the yes, please the NAME OF	CITY 1 Yes 2 No d time near a whire e where: r, CPAP, BiPAP o s device use a hu that apply) 1 S a healthcare setti complete the foli IS THIS FACILITY ALSO A TRANSPLANT	9 Unknown r any other midifier? Sterile 1 ing (e.g., ho	n i.e., hot tul respirator 1 Yes Distilled Dispital, lone.	o)? If yes, lis y therapy e 2 No 9 1 Bottle g term care	st dates quipme Unk ed 1 e/rehab/	er / / / / / / / / / / / / / / / / / / /	e treatment Other DATE (of sleep 1 Unknown ity, clinic)?		

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

2 🗌 No

9 Unknown

2 Long term care

3 Clinic

8 Other:

2 Outpatient

4 Employee

3 Usitor or volunteer

State Health Dept. Case No.:										
1 Definitely: Patient was hospitalized or a resident of a long term care facility 3 Possibly: Patient had exposure to a healthcare facility for a portion										
for the entire 10 days prior to onset	of the 10 days pr									
2 No: No exposure to a healthcare facility in the 10 days prior to onset	8 Other (specify)			9 <u></u>	Unknown					
20. In the 10 days before onset, did the patient visit or stay in an assisted living facility or senior living facility? (check one) 1 🗆 Yes 2 🗀 No 9 🗀 Unknown										
TYPE OF FACILITY TYPE OF EXPOSURE NAME OF F	ACILITY	CITY	STATE	DATE O	-					
				START DATE	END DATE					
1 Assisted Living 1 Resident 2 Visitor or Volunteer										
3 Employee										
2 Senior Living 1 Resident										
(Includes retirement 2 Visitor or Volunteer homes without skilled										
nursing or personal care) 3 Employee										
21. Was this case associated with a known outbreak or possible cluster?	(check one) 1 ☐ Yes 2 ☐ I	No 9 □ Unknown								
If yes, specify name of facility, city, and state of outbreak:										
PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY:	_									
1 CONFIRMED CASE	2 SUSPECT C	ASE								
1 Urine Antigen Positive: If yes,	4 Fourfold rise	in antibody titer OTHE	R THAN	l Legionella						
Date Collected:	pneumophila	serogroup 1 or to mult	tiple sp	ecies or						
Mo. Day Year	serogroups of	f Legionella using poo	ied anti	gen: IT yes	,					
	Initial (acute) titer:		الِـا لـ							
		Mo. Day Year								
2 Culture Positive: If yes,	Convalescent titer: Date Collected: Mo. Day Year									
Date Collected:	Species:	Species: Serogroup:								
Site: 1 lung biopsy 2 respiratory secretions (e.g., sputum, BAL) 3 pleural fluid	Direct Fluores	5 Direct Fluorescent Antibody (DFA) or								
4 Dlood 8 other (specify)		Immunohistochemistry (IHC) Positive: If yes,								
Species: Serogroup:	Date Collected:									
	Mo. Day Year Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleura									
	Site: 1 lung bloopsy 2 respiratory secretions (e.g., sputum, BAL) 3 pleural fluid 4 blood 8 other (specify)									
3 Fourfold rise in antibody titer to Legionella pneumophila serogroup 1: If yes,	Species:									
	6 Nucleic Acid	Assay (e.g., PCR): If y	es,							
Initial (acute) titer: Date Collected: Mo. Day Year	Date Collected:		7							
	Mo.	Day Year	_							
Convalescent titer: Date Collected: Mo. Day Year		respiratory secretions (e.g	ı., sputum,	BAL) 3 🗌 I	pleural fluid					
, in the second of the second	Species:		Serogroup):						
		REPORTIN			S					
Interviewer's Name: State Health Dept. Official v	who reviewed this report:	Local Health Dept. Pl								
The viewer's Name.	who reviewed this report.	State/DHD/SS								
Affiliation: Title:		State Health Dept. Return completed form to:								
				Respiratory Diseases Branch, Mailstop C25 Office of Infectious Diseases						
Telephone No.:	Telephone No.:			trol and P	-					
				Atlanta, GA						